

Subsidized Guardianship Request for Information to Determine Continued Eligibility

Use of form: This request for confirmation of continued eligibility is required under s. 48.623(4), Wis. Stats., to meet continued eligibility for subsidized guardianship payments. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

Name – Child (Last, First, MI)

Name – Guardian

Address – Guardian (Street, City, State, Zip Code)

This request for confirmation of continued eligibility is for: ☐ An Annual Review
☐ A change in child or guardian circumstance

Has any of the following occurred in the last year? If “Yes”, please provide the date of occurrence and requested supporting information.

Yes	No	Change in Circumstance	Date of Change	Supporting Information Requested – Documentation by Guardian
<input type="checkbox"/>	<input type="checkbox"/>	Has the family’s address changed? If “Yes”, indicate the date of the change and the supporting information.		New Address (Street, City, State, Zip Code)
<input type="checkbox"/>	<input type="checkbox"/>	Has there been a change in the child’s guardian? If “Yes”, indicate the date of the change and the supporting information.		Name – New Guardian Address – New Guardian (Street, City, State, Zip Code) Telephone Number – New Guardian Name of Circuit or Tribal Court Who Entered the Guardianship
<input type="checkbox"/>	<input type="checkbox"/>	Has the guardian stopped supporting the child or your legal responsibility for the child has ended? If “Yes”, indicate the date of the change and the supporting information.		The child is: <input type="checkbox"/> Deceased <input type="checkbox"/> Married <input type="checkbox"/> Entered the military <input type="checkbox"/> No longer living with you
<input type="checkbox"/>	<input type="checkbox"/>	Has the child graduated, completed, or dropped out from a full-time K-12 educational program or its equivalent?		If “Yes”, has the child: <input type="checkbox"/> Graduated <input type="checkbox"/> Completed high school equivalent program <input type="checkbox"/> Dropped out
<input type="checkbox"/>	<input type="checkbox"/>	Has the child been removed from the care of the guardian(s) and placed into out-of-home care? If “Yes”, indicate the date of the change and the supporting information.		Where is the child placed? What county, tribe, or other governmental agency has removed the child?
<input type="checkbox"/>	<input type="checkbox"/>	Has there been a change in health insurance benefits? If “Yes”, indicate the date of the change and the supporting information.		Name of New Policy New Health Insurance Policy Number

As the guardian(s), you are responsible to immediately notify the agency or department for the duration of the subsidized guardianship agreement when there is a change in the circumstances listed above. This form may be used to notify the agency or department of a change in circumstance between annual reviews as required in s. 48.623(4), Wis. Stats.

This form must be returned to _____
Name of Agency
located at _____ 15 calendar days prior to
Address of Agency (Street, City, State, Zip Code)
_____ or the subsidized guardianship payment will be suspended until the form is returned. Please contact
Annual Review Date
_____ if you have any questions regarding the completion of this form.
Fillable by Agency

WHAT ARE THE REQUIREMENTS FOR A CHILD AND GUARDIAN TO QUALIFY FOR CONTINUED SUBSIDIZED GUARDIANSHIP?

Your child must meet ALL of the following conditions to continue to be eligible for Subsidized Guardianship (payment and Medical Assistance):

1. You are still the child's guardian.
2. Your child is attending school full-time.
3. You are supporting your child.
4. Your child is not married.
5. Your child is not in the military.
6. Your child is living with you and you are supporting the child and are legally responsible for the child.
7. Your child has not been removed from your home by a county agency, tribal agency or other governmental agency and placed into out-of-home care.

Subsidized Guardianship benefits (payment and Medical Assistance) will continue until the month of high school graduation or age 19, whichever comes first. You will receive a notice when the child is 17 1/2 to complete regarding the child's eligibility after the age of 18.

If the child or the guardian(s) is no longer eligible to receive subsidized guardianship payments due to a change in circumstance that affects eligibility listed above, the payments will be discontinued on the date the child or the guardian(s) is no longer eligible as stated in the original subsidized guardianship agreement.

The guardian(s) may appeal the agency or department's decision within 45 days of the notice to terminate the subsidized guardianship agreement or payment in accordance with rules and procedures of the state's fair hearing and appeal process.

A request for a Hearing shall be in writing addressed to: Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707

The information given above is true and complete to the best of my knowledge.

SIGNATURE – Guardian

Date Signed

Telephone Number (Daytime)

MAKE A COPY OF THIS FORM FOR YOUR PERSONAL RECORDS.

☐ 1st Notice ☐ 2nd Notice Provider ID Number: _____